

**GEORGIA DEPARTMENT OF HUMAN RESOURCES**

**DIVISION OF MENTAL HEALTH, DEVELOPMENTAL  
DISABILITIES AND ADDICTIVE DISEASES**

**APPLICATION TO BECOME A PROVIDER OF  
MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES  
HOME AND COMMUNITY BASED WAIVER SERVICES**

**OR ANY**

**MENTAL RETARDATION AND DEVELOPMENTAL  
DISABILITIES SERVICES  
AUTHORIZED IN WHOLE OR IN PART  
BY  
THE DIVISION OF MHDDAD**



**DHR**

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## SECTION I. OVERVIEW

It is the responsibility of the Division of Mental Health, Developmental Disabilities and Addictive Diseases (Division of MHDDAD) to review provider applications for compliance with Medicaid Conditions of Participation and with the Division of MHDDAD *Standards for All Providers*.

Additionally, the Division of MHDDAD seeks to assure that providers of services to MHDDAD consumers 1) are competent to provide the services; 2) are qualified to provide the services; and 3) have the infrastructure necessary to provide quality services.

Here are some things to think about before you begin the process of completing the application:

- ❑ Know what services you are planning to provide
  - You must make a **separate application for Mental Retardation and Developmental Disabilities (MRDD) services using THIS application**
  - You must make a **separate application for Mental Health and Addictive Diseases (MHAD) services**

**NOTE: Do not** use this document to make application to provide MHAD services. See the MHAD application documents for adult services and for children's services at the MHDDAD web site

- ❑ Review the requirements for providing the service(s) you seek to provide
  - Make sure you can meet these requirements
- ❑ Review the application directions
- ❑ Complete all sections of the application, including all attachments
  - Be sure you submit policies, procedures and other documentation required
  - Be sure that all information is current within at least 30 days of your application
- ❑ Use the Department of Human Resources (DHR) Division of MHDDAD FY07 Provider Manual, **applicable to all providers doing business with MHDDAD**, to write the policies and procedures you are required to submit
  - In particular, review the *Standards for All Providers* found in the FY07 Provider Manual Part II, Section II in the Community Service Standards document (available at the Provider Information link on this web page: <http://mhddad.dhr.georgia.gov>)
  - **NOTE:** If you are an accredited provider, you may elect to submit policies prepared for and approved by the accrediting agency. **However**, be certain the policies are aligned with the *Standards for All Providers*.
- ❑ Submit all required information in a 3 ring binder
- ❑ Put the required documentation in the binder behind a tab labeled with each item required
- ❑ Tab the required documentation according to the order of items listed on the application

**When you have completed all requirements** of the application, submit the three ring binder by **USPS, Federal Express or by UPS** to:

Provider Application  
Provider Certification Unit  
Division of Mental Health, Developmental Disabilities and Addictive Diseases  
2 Peachtree Street, 22<sup>nd</sup> Floor  
Atlanta, Georgia 30303

**DO NOT hand deliver the binder.** Your application will be date-stamped when received, and you will be notified by E-mail that it has been received.

**BE SURE TO KEEP A FULL COPY FOR YOURSELF!**

## **SECTION II. MEDICAID CONDITIONS of PARTICIPATION for PROVIDERS MAKING APPLICATION TO BILL for MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES SERVICES**

**Any entity wishing to be approved to bill Medicaid for Mental Retardation and Developmental Disabilities services must review and meet the following Medicaid requirements and conditions of participation.**

- ❑ Division of Medical Assistance (DMA or Medicaid) policies and procedures, applicable to any provider seeking to provide services through the Division of Medical Assistance, available at [www.ghp.georgia.gov](http://www.ghp.georgia.gov).
  - Click on the Provider Information tab
  - Click on view full list in the box titled Medicaid Provider Manuals
- ❑ Review these two manuals carefully
  - [Part I Policies and Procedures / Billing Manual](#) and
  - [Mental Retardation Waiver Program](#)

## **SECTION IIIA. PROCESS for PROVIDER APPLICATION TO BILL for MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES SERVICES**

- ❑ Go to <http://mhddad.dhr.georgia.gov>
  - Click on Provider Information
  - Click on FY 2007 Provider Manual
    - Click on Part I: [Section II: DD Consumer Eligibility, Access and Planning List, Service Definitions and Service Guidelines](#)
      - Read through the entire document. This is good background information to help you understand the services available to MRDD consumers

## **SECTION IIIB. SERVICE MIX for SERVING PERSONS WITH MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES**

You may make application to provide any of the following MRDD services that are in the table that follows. Note that the CHSS Waiver is a closed waiver and is not accepting new providers. Note also that the following services are procured through RFP:

1. T2040 Consumer Directed Natural Support Financial Support Services
2. T2022 Support Coordination
3. T1023 Intake & Evaluation Services
4. H2011 Behavioral Support Team Services

*You must show evidence of meeting the program parameters and staff qualifications for each service you propose to provide.*

### FORM 1: MRWP HOME AND COMMUNITY BASED WAIVER SERVICES<sup>1</sup>

Indicate by your initials in the far left column the service(s) for which you are making application			
	HIPAA Code	Old "Y" Code	
	T2016	Y3300	Habilitation: Residential habilitation/Independent Living Skills Development (Formerly described as Residential Training + Supervision Minimal Support <b>Level I</b> )
	T2016 TF	Y3301	Habilitation: Residential habilitation/Independent Living Skills Development (Formerly described as Residential Training + Supervision Moderate Support <b>Level II</b> )
	T2016 TG	Y3302	Habilitation: Residential habilitation/Independent Living Skills Development (Formerly described as Residential Training + Supervision Major Support <b>Level III</b> )
	T2216 U2	Y3303	Habilitation: Residential habilitation/Independent Living Skills Development (Formerly described as Residential Training + Supervision Intensive Support <b>Level IV</b> )
	T2019	Y3316	Habilitation: Supported Employment
	T2021	Y3326	Day Habilitation
	T2025 U5	Y3319	Waiver Services, not otherwise specified (NOS) (Formerly described as Personal Support)
	T2025	Y3341	Waiver Services, not otherwise specified (NOS) (Formerly described as Day Supports - <b>Monthly</b> )
	T2025 U1	Y3341	Waiver Services, not otherwise specified (NOS) (Formerly described as Day Supports – <b>60 Hours</b> )
	T2025 U2	Y3341	Waiver Services, not otherwise specified (NOS) (Formerly described as Day Supports – <b>30 Hours</b> )
	T2025 U3	Y3341	Waiver Services, not otherwise specified (NOS) (Formerly described as Day Supports – <b>40 Hours</b> )
	T2025 U4	Y3343	Waiver Services, not otherwise specified (NOS) (Formerly described as Natural Support Enhancement Services)
	T2025 U8	Y3344	Waiver Services, not otherwise specified (NOS) (Formerly described as Natural Support Therapies)
	T2025 UC		Consumer Directed Natural Support Enhancement Services
	T2028	Y3322	Specialized supply, Not otherwise specified (NOS) (Formerly described as Specialized Medical Supplies)
	T2029	Y3323	Specialized medical equipment, not otherwise specified (NOS) (Formerly described as Specialized Medical Equipment)
	T2039	Y3321	Vehicle Modifications, waiver (Formerly described as Vehicle Adaptation)
	S5150	Y3312	Unskilled Respite care, non hospice (Formerly described as Respite Intensive Support <b>Level I</b> )
	S5150 TF	Y3312	Unskilled Respite care, non hospice (Formerly described as Respite Intensive Support <b>Level II</b> )
	S5150 TG	Y3312	Unskilled Respite care, non hospice (Formerly described as Respite Intensive Support <b>Level III</b> )
	S5150 U2	Y3312	Unskilled Respite care, non hospice (Formerly described as Respite Intensive Support <b>Level IV</b> )
	S5165	Y3320	Environmental Adaptations / Modifications

<sup>1</sup> Submit a signed copy of both pages indicating the services for which you are making application

***By the submission of this application, the organization or entity declares that the organization or entity is*** (select one of the following statements):

- ☐ A new (never approved) provider making application to be approved as a provider of MRDD services.
- ☐ A currently approved provider for the Division of MHDDAD making application to be approved as a provider of MRDD services. .

**Directions for completing and processing FORM 1, pages 6-8:**

1. Submit the original of page 6-8 with your application.
  - a. Place these two pages as the first items in your three ring binder when making application to be a provider of MRDD services

**FORM 1 (continued):**

**To the Division of MHDDAD:**

I, \_\_\_\_\_,  
(To be completed by the CEO, Executive Director or other Authorized Agent - please print)

The undersigned and agent for

\_\_\_\_\_  
(Indicate the agency or organizational name as registered at the Secretary of State's office, including "dba" if applicable - please print)

Do hereby make application to the Department of Human Resources, Division of Mental Health, Developmental Disabilities and Addictive Diseases to be a provider of MRDD services.

This organization proposes to serve:

☐ Children only      ☐ Adults only      ☐ Both children and adults

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

**Printed Name** \_\_\_\_\_ **Title** \_\_\_\_\_

Telephone \_\_\_\_\_

Fax \_\_\_\_\_

E-mail \_\_\_\_\_

If you have ever provided any of the proposed services, on a separate page complete and submit the following information with your application:

1. Name of service
2. Number of clients served most recent fiscal year
3. Outcomes produced
4. Do you currently offer this service?



## **SECTION IV. PROCESS for PROVIDER APPLICATION TO BILL for STATE CONTRACT FUNDED MENTAL RETARDATION and DEVELOPMENTAL DISABILITIES SERVICES**

### **FORM 2. State Contract Funded MRDD Services.**

There are a very few MRDD services that are state supported and NOT billable through Medicaid. If you are making application for these services, please indicate by checking one or both boxes. **Note: The Medicaid requirements and conditions of participation** (available at [www.ghp.georgia.gov](http://www.ghp.georgia.gov)) **do not apply.**

- ☐ Comprehensive Day Services
- ☐ Contract Funded Community Residential Services
- ☐ Family Supports

***By the submission of this application, the organization or entity declares that the organization or entity is*** (select one of the following statements):

- ☐ A new (never approved) provider making application to be approved to provide the above noted State Contract Funded MRDD Services.
- ☐ A currently approved provider for the Division of MHDDAD making application to be approved to provide the above noted State Contract Funded MRDD Services.

### **Directions for completing and processing FORM 2, pages 9-10:**

2. Submit the original of pages 9-10 with your application.
  - a. Place these two pages as the first items in your three ring binder when making application to be a State Contract Funded MRDD Services Provider

**FORM 2 (continued):**

**To the Division of MHDDAD:**

I, \_\_\_\_\_,  
(To be completed by the CEO, Executive Director or other Authorized Agent - please print)

The undersigned and agent for

\_\_\_\_\_  
(Indicate the agency or organizational name as registered at the Secretary of State's office, including "dba" if applicable - please print)

Do hereby make application to the Department of Human Resources, Division of Mental Health, Developmental Disabilities and Addictive Diseases to provide the state contract funded MRDD services (as indicated by a checkmark on page 9).

This organization proposes to serve:

☐ Children only      ☐ Adults only      ☐ Both children and adults

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

**Printed Name** \_\_\_\_\_ **Title** \_\_\_\_\_

Telephone \_\_\_\_\_

Fax \_\_\_\_\_

E-mail \_\_\_\_\_

If you have ever provided any of the proposed services, on a separate page complete and submit the following information with your application:

1. Name of service
2. Number of clients served most recent fiscal year
3. Outcomes produced
4. Do you currently offer this service?

## SECTION V. LICENSING OF PROPOSED MRDD SERVICE (S)

If you are making application for **any service that requires a license**, you **MUST** submit a current copy of that license with this application. If you are unsure of whether your proposed service(s) require a license, do the following steps:

- ❑ Go to the web site for the State of Georgia Office of Regulatory Services which can be found at <http://ors.dhr.georgia.gov/portal/site/DHR-ORS/>
- ❑ Click on the “Services” tab
  - Look through services described under Primary Health Care
    - For example, supporting persons in their own home (property that they own, lease or reside in with family) requires that the **agency** providing the support have a [Private Home Care Providers](#) license
  - Look through services described under Long-Term Care
    - For example, provision of residential services for two or more unrelated adults (regardless of disability) must be licensed under
      - Community Living Arrangements (*note that you must have Regional Office approval to make application for this license*) or
      - Personal Care Homes
    - If you plan to provide residential services to children, look through information found under Residential Child Care, specifically
      - Child Care Institutions
      - If you are serving children, you may also apply for a waiver for the Community Living Arrangements license

Refer also to the table that follows. .

HIPAA CODE	Old “Y” Code	PROPOSED SERVICE	LICENSE REQUIRED
T2016	Y3300	Habilitation: Residential habilitation/Independent Living Skills Development (Formerly described as Residential Training + Supervision Minimal Support <b>Level I</b> )	<input type="checkbox"/> Personal Care Home <input type="checkbox"/> Community Living Arrangement <input type="checkbox"/> Child Care Institutions
T2016 TF	Y3301	Habilitation: Residential habilitation/Independent Living Skills Development (Formerly described as Residential Training + Supervision Moderate Support <b>Level II</b> )	<input type="checkbox"/> Personal Care Home <input type="checkbox"/> Community Living Arrangement <input type="checkbox"/> Child Care Institutions
T2016 TG	Y3302	Habilitation: Residential habilitation/Independent Living Skills Development (Formerly described as Residential Training + Supervision Major Support <b>Level III</b> )	<input type="checkbox"/> Personal Care Home <input type="checkbox"/> Community Living Arrangement <input type="checkbox"/> Child Care Institutions
T2216 U2	Y3303	Habilitation: Residential habilitation/Independent Living Skills Development (Formerly described as Residential Training + Supervision Intensive Support <b>Level IV</b> )	<input type="checkbox"/> Personal Care Home <input type="checkbox"/> Community Living Arrangement <input type="checkbox"/> Child Care Institutions
T2025 U4	Y3343	Waiver Services, not otherwise specified (NOS) (Formerly described as Natural Support Enhancement Services)	<input type="checkbox"/> Private Home Care Providers
T2025 U5	Y3319	Waiver Services, not otherwise specified (NOS) (Formerly described as Personal Support)	<input type="checkbox"/> Private Home Care Providers
T2025 U8	Y3344	Waiver Services, not otherwise specified (NOS) (Formerly described as Natural Support Therapies)	<input type="checkbox"/> License as required by the profession
		State Contract Funded Community Residential Services	<input type="checkbox"/> Personal Care Home <input type="checkbox"/> Community Living Arrangement <input type="checkbox"/> Child Care Institutions

## SECTION VI. ACCREDITATION REQUIREMENTS

National accrediting organizations approved and recognized by the Division of Mental Health, Developmental Disabilities and Addictive Diseases are the following:

- ❑ **CARF** – The Rehabilitation Accreditation Commission
  - [www.carf.org](http://www.carf.org)
- ❑ **JCAHO** – The Joint Commission on Accreditation of Healthcare Organizations
  - [www.jointcommission.org](http://www.jointcommission.org)
- ❑ **The Council** – The Council on Quality and Leadership
  - [www.thecouncil.org](http://www.thecouncil.org)
- ❑ **COA** – Council on Accreditation
  - [www.coanet.org](http://www.coanet.org)

**Submit a copy of accreditation with your application** if you are accredited and in good standing with one of these accrediting organizations. *The Division will show preference for contracts or letters of agreement with new providers who are currently accredited.*

Additionally, if you plan to do business with one of the Care Management Organizations (CMO) in Georgia doing business with Georgia Medicaid, you must be accredited.

## SECTION VII. ADDING SERVICES IF YOU ARE ALREADY AN APPROVED PROVIDER

### 1. Current MRDD provider adding MRDD services

- ❑ Review MRDD service descriptions
  - Identify services for which you are making application
  - Determine qualifications necessary for service provision
  - Determine the staff qualifications and mix that you will need
- ❑ Submit all documentation required to show evidence of your qualifications to provide the specialty service
  - Don't forget to submit the corresponding policies, procedures and staffing patterns that may apply to the proposed service
- ❑ Check to see if a license is required for any service you propose to do
  - Begin the licensure application process if necessary
    - **Evidence of licensure must be in place BEFORE this application is submitted**
- ❑ **Submit information required in Section IIIB.**

## 2. Adding State Contract Funded MRDD services

- ❑ Follow the complete instructions published in this manual
  - **All requirements for approval must be addressed**
- ❑ Submit information required in Section IV.

## SECTION VIII. COMPLETING THE APPLICATION PROCESS

At this point, you should have done the following:

- ❑ Reviewed the Division of Medical Assistance (DMA or Medicaid) policies and procedures, applicable to any provider seeking to provide services through the Division of Medical Assistance, available at [www.ghp.georgia.gov](http://www.ghp.georgia.gov).
  - Clicked on the Provider Information tab
  - Clicked on view full list in the box titled Medicaid Provider Manuals
    - Reviewed these two manuals carefully
      - [Part I Policies and Procedures / Billing Manual](#) and
      - [Mental Retardation Waiver Program](#)
- ❑ Reviewed the MHDDAD FY07 Provider Manual at <http://mhddad.dhr.georgia.gov>
  - Clicked on Provider Information
  - Clicked on FY 2007 Provider Manual
    - Clicked on Part I: [Section II: DD Consumer Eligibility, Access and Planning List, Service Definitions and Service Guidelines](#)
      - Read through the entire document. This is good background information to help you understand the services available to MRDD consumers
    - Clicked on Part II: Community Service Standards, [Section II: General Service Standards](#)
      - Read through pp 1-28
        - To further understand the philosophy of provision of services, supports, care or treatment of persons served through the Division of MHDDAD and its approved providers
        - To further understand requirements for providers as delineated in these *Standards for Providers*
        - To prepare for developing policies and procedures
- ❑ Checked to see if a license is required for any service you propose to provide
  - Begin the licensure application process if necessary
    - Evidence of licensure must be in place **BEFORE** this application is submitted

*Now it is time to complete the remaining components of this application.*

**THIS APPLICATION WILL BE RETURNED TO THE APPLICANT IF NOT COMPLETE.**

<b>SECTION IX. PROCEED TO THE ATTACHMENT PORTION OF THIS DOCUMENT</b>
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1. Complete Attachment I
  - a. Make a tab for Attachment I and insert all information required under Attachment I. Be sure to include **ALL** information requested.
2. Complete all information noted in Attachment II Section I, *Professional and General Liability Information*, answering each question. **Use added pages as required.**
  - a. Make a tab for Attachment II Section I and insert this information.
3. Complete all information noted in Attachment II Section II, *Agency Specific Information*.
  - a. Submit all information required in items 1-5.
  - b. Make a tab for Attachment II Section II and insert this information.
4. Complete all organizational policies and procedures listed in Attachment III as they apply to the services you propose.
  - a. Use the DHR/MHDDAD FY07 Provider Manual, **applicable to all providers doing business with MHDDAD**, to write the policies and procedures you are required to submit
    - i. In particular, review the *Standards for All Providers* found in the FY07 Provider Manual Part II, Section II (available at <http://mhddad.dhr.georgia.gov>)
    - ii. **NOTE:** if you are an accredited provider, you may elect to submit policies prepared for and approved by the accrediting agency. **However,** be certain the policies are aligned with the *Standards for All Providers*.
5. Complete all information as specified in Attachment IV, Sections I, II, III and IV.
  - a. When completing Sections III and IV, be sure you address EVERY SERVICE and SITE LOCATION that you propose.
    - i. Make a tab for **each service** you propose.
    - ii. Specify the service delivery location for each service and site location that you propose
    - iii. Identify all staff associated with the proposed service
6. Complete Attachment V if you are currently or have been (within the past 24 months) a subcontractor for a service provider.
7. Complete Attachment VI, Attestations.
8. Complete the Medicaid application found at [www.ghp.ga.gov](http://www.ghp.ga.gov). Put that under its own tab as the last entry in your binder. Note that you also need to include with the Medicaid application the following:
  - a. Statement of Participation (DMA002)
  - b. Provider Enrollment Application (DMA001)
  - c. Request for Taxpayer Identification (W9)
  - d. Electronic Funds Transfer Agreement (DMA001A), and
  - e. Disclosure of Ownership and Control Interest Statement.

## SECTION X. NOW WHAT HAPPENS?

1. You will be notified by e-mail when your application has been received and date-stamped.
2. Your application will be reviewed in the order of receipt.
3. You will be notified when the review of your application has started.
4. Communicate **only** by e-mail. The person reviewing your application must have large blocks of time to do the work, thus e-mail is the best way to communicate.
5. You will be sent a formal written status report.
  - a. If there are corrections to be made, you will be notified.
    - i. There are two opportunities for correction
    - ii. The time lines for correction are very clearly stated in the status report
6. If your application is satisfactory<sup>2</sup> and you are making application to do medicaid services through the Division of MHDDAD, the Division will recommend to the Division of Medical Assistance (Medicaid) that you become a provider of MHDDAD services. You will be copied
  - a. Your Medicaid application will be forwarded to the Division of Medical Assistance
7. If your application is satisfactory and you are making application to do state funded services, APS Healthcare, the external review organization for DHR MHDDAD will be notified that you have been approved. You will be copied.
8. If your application is **not** satisfactory after two attempts to correct, you may re-apply **no sooner than 12 calendar months from the date of the letter notifying you that your application is not satisfactory.**

## SECTION XI. I HAVE RECEIVED MY PROVIDER NUMBER (S) FROM MEDICAID. NOW WHAT DO I DO?

It is your responsibility to contact the Division of MHDDAD regional office representing the area of the state in which you wish to offer services to secure a contract or Letter of Agreement **prior to beginning to offer the services you are approved to provide.**

Contracts and agreements for consumer services are made and entered into by and between the Department of Human Resources through its Division of Mental Health, Developmental Disabilities and Addictive Diseases. Meeting all of the requirements to be an approved provider **does not automatically insure** that you will be awarded a contract or Letter of Agreement. For example, if there are not enough dollars to purchase your services you will not be awarded a contract. Your application will be noted as approved and maintained on file

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<sup>2</sup> The Division of MHDDAD regional office will visit proposed residential services and may also elect to visit any proposed service site.

